Senate Bill No. 1142

CHAPTER 251

An act to amend Section 1872.85 of the Insurance Code, relating to health insurance.

[Approved by Governor August 22, 2014. Filed with Secretary of State August 22, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1142, Monning. Health insurance fraud: annual special purpose assessments.

Existing law provides for the regulation of disability insurers by the Insurance Commissioner. Existing law requires every admitted disability insurer or other entity liable for any loss due to health insurance fraud doing business in California to pay an annual special purpose assessment that does not exceed $0.20 per year for each insured under an individual or group insurance policy it issues in this state, in order to fund increased investigation and prosecution of fraudulent disability insurance claims. Existing law requires that 30% of those funds be distributed to the Fraud Division of the Department of Insurance for enhanced investigative efforts and that the other 70% be distributed to local district attorneys for the investigation and prosecution of disability insurance fraud cases, as specified.

This bill would instead require that the annual special purpose assessment be paid for each person in this state covered under an individual or group policy regardless of the situs of the contract or master group policyholder, and regardless of whether the insured has been issued an individual certificate of coverage, including blanket insurance. The bill would also require that the data supporting the special purpose assessment not be required to be submitted more often than once each calendar year, except that responses to questions from the commissioner and clarifying information regarding the data would not be considered as additional submissions of data. The bill would authorize, for group and blanket insurance contracts, insurers to rely on information requested from and provided by the group policyholder after a reasonable effort to obtain timely and accurate information.

The people of the State of California do enact as follows:

SECTION 1. Section 1872.85 of the Insurance Code is amended to read:

1872.85. (a) Every admitted disability insurer or other entity liable for any loss due to health insurance fraud doing business in this state shall pay an annual special purpose assessment to be determined by the commissioner, but not to exceed twenty cents ($0.20) annually for each person in this state

covered under an individual or group insurance policy regardless of the situs of the contract or master group policyholder, and regardless of whether the insured has been issued an individual certificate of coverage, and including blanket insurance as defined in Section 10270.2, in order to fund increased investigation and prosecution of fraudulent disability insurance claims. The data supporting the special purpose assessment shall not be required to be submitted more often than once each calendar year, except that responses to questions from the commissioner and clarifying information regarding the data shall not be considered as additional submissions of data. For group and blanket insurance contracts, insurers may rely on information requested from and provided by the group policyholder after a reasonable effort to obtain timely and accurate information. After incidental expenses, 30 percent of those funds received from the assessment per insured shall be distributed to the Fraud Division of the Department of Insurance for enhanced investigative efforts, and 70 percent of the funds shall be distributed to local district attorneys, pursuant to subdivisions (b) and (c), for investigation and prosecution of disability insurance fraud cases. The funds received pursuant to this section shall be deposited into the Disability Insurance Fraud Account, which is hereby created in the Insurance Fund, and shall be expended and distributed, when appropriated by the Legislature, only for enhanced investigation and prosecution of disability insurance fraud.

In the course of its investigation, the Fraud Division shall aggressively pursue all reported incidents of probable fraud and, in addition, shall forward to the appropriate disciplinary body the names of any individuals licensed under the Business and Professions Code who are convicted of engaging in fraudulent activity along with all relevant supporting evidence.

(b) The commissioner shall distribute funds pursuant to subdivision (a) to district attorneys who are able to show a likely positive outcome that will enhance the prosecution of disability insurance fraud in their jurisdiction based on specific criteria promulgated by the commissioner. A district attorney desiring funds pursuant to subdivision (a) shall submit to the commissioner an application that includes, but is not limited to, all of the following:

(1) The proposed use of the moneys and the anticipated outcome.

(2) A list of all prior cases or projects in the district attorney's jurisdiction that have been funded under the provisions of this section, and a copy of the final accounting for each case or project. If a case or project is ongoing, the most recent accounting shall be provided.

(3) A detailed budget for the moneys, including salaries and general expenses, that specifically identifies the purchase or rental cost of equipment or supplies.

(c) (1) A district attorney who receives moneys pursuant to this section shall submit a final detailed accounting at the conclusion of each case or project funded. For a case or project that continues for longer than six months, an interim accounting shall be submitted every six months, or as otherwise directed by the commissioner.

(2) A district attorney who receives moneys pursuant to this section shall submit a final report to the commissioner, which may be made public, as to the success of each case or project funded by this section. The report shall provide information and statistics on the number of active investigations, arrests, indictments, and convictions associated with a case or project. The applications for moneys, the distribution of moneys, and the annual report required by Section 1872.9 shall be public documents.

(3) Notwithstanding any other provision of this section, information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential.

(4) The commissioner may conduct a fiscal audit of the programs administered under this subdivision. The fiscal audit shall be conducted by an internal audit unit of the department. The cost of fiscal audits shall be paid from the Disability Insurance Fraud Account, upon appropriation by the Legislature.

(5) If the commissioner determines that a district attorney is unable or unwilling to investigate or prosecute a relevant disability insurance fraud case, the commissioner may discontinue distribution of moneys allocated for that matter pursuant to this section, and may redistribute moneys to other eligible district attorneys.

(d) Activities of the Fraud Division with regard to investigating and prosecuting fraudulent disability insurance claims pursuant to this section shall be included in the report required by Section 1872.9.

(e) This section shall not apply to policies issued by a reciprocal or interinsurance exchange, as defined by Sections 1303 and 1350, or coverage provided by or through a motor club, as defined by Section 12142, affiliated with a reciprocal or interinsurance exchange, if the annual premium charged for the coverage or the annual cost to the insurer for providing that coverage does not exceed one dollar ($1) per insured.

(f) The commissioner shall adopt regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

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